

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13737

1003

State File No. 3559

BIRTH NO. 49-024532 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN) St Louis		c. LENGTH OF STAY (in this place) 5 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OVERLAND	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Lukes 5 DAYS		d. STREET ADDRESS (If rural, give location) 9616 Freccatt			
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) THOMAS		c. (Last) EVANS	
4. DATE OF DEATH (Month) (Day) (Year) 4-19-49		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH 4-13-49		9. AGE (In years last birthday) 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME James T. Evans		13b. MOTHER'S MAIDEN NAME Mary Noonan	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME James T. Evans		ADDRESS 9616 Freccatt		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Respiratory Cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 5 days		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypo glycoemia (Pancreatic disease of New Born) DUE TO (c) Hemorrhagic Disease of New Born	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pyloric obstruction.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Overland MO		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 7710		22. I hereby certify that I attended the deceased from 4-13, 1949, to 4-19, 1949, that I last saw the deceased alive on 4-19-49, 19, and that death occurred at 4:20 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Melvina Roblee		(Degree or title) M.D.		23b. ADDRESS 3720 Washington	
23c. DATE SIGNED 4-21-49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-20-49	
24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) St Louis		(State) MO	
DATE REC'D BY LOCAL REG. 4-20-		REGISTRAR'S SIGNATURE J. B. Casate		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cuffler 4306 Lindell	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 20 1949

(Licensed Embalmer's Statement on Reverse Side)

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.